throughout the country. In that role, they often pose a serious competitive threat to hospitals. These facilities, often owned by physician investors, provide surgical procedures to patients who do not require overnight care by physicians or other health care professionals.[2] As such, they compete directly with hospitals that provide similar services in either an inpatient or outpatient setting, often taking business away from them. Recognizing ASCs' potential to reign in health care spending by offering low-risk surgeries in a lower-cost and patient-friendly environment, Congress provided in the early 1980s that Medicare should cover the facility costs of ASCs for certain services as it did for hospital services. *See* Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 934, 94 Stat. 2599 (1980). Since then, with advances in technology, the range of services safely provided in ASCs and covered by Medicare and other payers has greatly expanded.

Since the 1980s, the number of ASCs has grown rapidly, doubling in the past decade and now totaling over 4,400.[3] There are many reasons for this growth. First, ASCs ensure benefits to patients and physicians alike. They offer consumers more convenient locations, briefer wait times on-site, shorter delays in scheduling surgery, and often lower

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[2] *See* Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment Policy*, § 2F, at 136, 140 (2003) [hereinafter "MedPAC 2003], *available at* http://www.medpac.gov/publications/congressional_reports/Mar03_Entire_report.pdf.

[3] *See* Fed. Trade Comm'n & Dep't of Justice, Improving Health Care: A Dose of Competition (July 2004), at Chapter 3, at 24, (July 2004) [hereinafter "FTC/DOJ Report"] *available at* http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf; Am. Soc'y of Anesthesiologists Newsletter, Vol. 69, "Hospital Contracts Survey: 2004 Data," (April 2005), *available at* http://www.asahq.org/Newsletters/2005/04-05/pracMgmt04_05.html.

coinsurance payments than hospital outpatient departments.[4] Their concentration in specialized procedures, using state-of-the-art medical technology in facilities staffed by specially trained personnel, enables them to provide better care at greater satisfaction to patients than more generalized care providers.[5] Physicians in turn benefit from the increased efficiencies of using facilities designed for specific outpatient procedures. *See* MedPAC 2003, *supra* note 2, at 140. Because physicians retain control over the surgical calendar at ASCs, they may schedule more surgeries per day, which increases their fee generation ability, improves productivity, and decreases downtime. *See* Casalino, "Focused Factories," *supra* note 5, at 5; Shapiro Testimony, *supra* note 1, at 4.

Second, innovations in technology have allowed ASCs to offer an increasing range of services as outpatient procedures, transforming the way some maladies are treated. In the late 1990s in particular, physicians began performing several high-volume procedures in an ambulatory care rather

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[4] *See* MedPac 2003, *supra* note 2, at 140 (noting ASC copayments of 20 percent as compared with hospital outpatient copayments of up to 55 percent). *See also* Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment Policy*, Table 3F-1, at 187 (2004) [hereinafter "MedPac 2004"], *available at* http://www.medpac.gov/publications/congressionalreports/June04_Entire_Report.pdf (noting ASC coinsurance tended to be 10 to 60 percent lower than hospital outpatient coinsurance).

[5] *See* Lawrence P. Casalino *et al*, "Focused Factories? Physician-Owned Specialty Facilities," *Health Affairs*, Vol. 22, No. 6 (Nov./Dec. 2003) at 5-6, *available at* http://aaasc.org/advocacy/documents/FocusedFactoriesHealthAffairs1103.pdf; Richard P. Kusserow, Inspector General, Dept. of Health & Human Servs., "Patient Satisfaction with Outpatient Surgery: A National Survey of Medicare Beneficiaries," at 3-4, (1989), *available at* http://oig.hhs.gov/oei/reports/oei-09-88-01002.pdf.

than inpatient setting. *See* MedPAC 2003, *supra* note 2, at 139. For example, advances in microsurgery and ultrasound techniques have permitted better cataract lens replacements to be performed safely and more frequently in ASC settings. *Id.*, at 140. Migrating services from the inpatient hospital environment to lower-risk, lower-cost outpatient settings allows patients and payors alike to reap these benefits and encourages further technological advances.

Finally, ASCs can offer cost benefits not just to patients who have smaller copays, but to the government as well. For example, cataract removal or lens insertion makes up about half of the Medicare funds received by ASCs, yet ASCs' Medicare reimbursement rates for these services are at least 19 percent lower than those charged by hospital outpatient departments. *See* MedPAC 2003, *supra* note 2, at 140 & Table 2F-2; FTC/DOJ Report, *supra* note 3, at 26.[6] Comparing Medicare reimbursement rates generally, the government pays higher rates to hospitals for 2,267 procedures, and higher rates to ASCs for only 280 procedures.[7] Recent legislation, effective January 1, 2007, brings all higher ASC reimbursements down to the level of those paid to hospital outpatient departments. *See* Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 5103, 120

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[6] In 2006, the rate gap between ASCs and hospitals for this procedure became even more disparate. *Compare* 70 Fed. Reg. 68734 (Nov. 10, 2005) (listing hospital reimbursement rate for cataract procedures with IOL insert at $1,387.71) *with* U.S. Dep't of Health & Human Srvs., Medicare Claims Process Manual, CMS 100-04, Change Request 4075 (Sept. 30, 2005) (noting 2006 ASC reimbursement rates for the procedure were unchanged at $973).

[7] *See* Lena Robins *et al.*, "Deficit Reduction Act of 2005 Enacts Sweeping Medicare & Medicaid Changes," *Mondaq*, Feb. 17, 2006, *available at* http://www.mondaq.com/i_article.asp_Q_articleid_E_37888.

Stat. 4, 40 (2006). In this way, ASCs are fulfilling the purpose for which they were intended by applying increasing pressure against hemorrhaging health care costs.

For all of these reasons, ASCs have become increasingly popular with both patients and physicians. Congress has increased the services for which ASCs can receive Medicare reimbursement, and those payments to ASCs have more than tripled between 1992 and 2002, with total Medicare payments of $1.9 billion to ASCs in 2002. *See* MedPAC 2004, *supra* note 4, § 3F, at 186.[8] These results have affected and will continue to impact the bottom line at hospitals, because hospitals would otherwise perform and receive facility fees for these services.

Despite – and in some ways because of – the success of ASCs, physicians who desire to work at or open an ASC sometimes face hurdles imposed by hospitals, particularly in local areas where a single hospital has a dominant market position. Medicare currently does not offer facility reimbursement for all surgical procedures, and some individual patients may have conditions requiring inpatient admission. Doctors whose practice depends on their ability to also perform procedures on a hospital inpatient basis must retain their hospital privileges in order to practice effectively. This dependence is especially keen where the law requires physicians practicing at an ASC to have hospital staff privileges and/or transfer agreements with hospitals. *See* App. at 83; U.S. Dep't. of Health & Human Srvs., Medicare

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[8] The Department of Health and Human Services announced that in 2008, Medicare will significantly expand the list of services for which ASCs receive facility reimbursement. *See* AAASC release, "Medicare Commits to Significantly Expand Coverage of Services Within ASC," *available at* http://www.aaasc.org/advocacy/MedicareCommitstoSignificantlyExpandCoverageofServicesWithinASC.htm.

State Operations Manual, App. L, § 416.41 (2004), *available at* http://www.cms.hhs.gov/manuals/downloads/som107_Appendicestoc.pdf.

A 2004 joint Federal Trade Commission and Department of Justice Antitrust Division report, produced after extensive hearings and submissions, records panelists' observations of the various ways in which hospitals have tried to thwart further ASC entry. *See* FTC/DOJ Report, *supra* note 3, Chapter 3, at 27.[9] Such practices included "revok[ing] privileges of physician-investors in ASCs, and us[ing] state certificate of need (CON) laws to inhibit ASC entry." *Id.* Because physicians often remain dependent on hospitals due to the hospital's position in the marketplace, they are vulnerable to such attacks and require the full protection provided to them by the federal antitrust laws.

B. HCQIA's Clear Language Limits Antitrust Immunity Where Hospitals Use The Peer Review Process In Certain Specified Respects.

The courts below granted Lewistown Hospital (the "Hospital") immunity from antitrust damages on the basis of HCQIA, enacted in 1986. HCQIA was designed to provide hospitals with legal protection from damage claims in connection with *bona fide* peer review of physician competence and professional conduct, while preserving full application of the antitrust and other laws to hospital actions based on enumerated competitive acts by physicians. Congress was concerned that absent immunity, physicians who were aggrieved by adverse peer review decisions would

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[9] *See id.* at 22 n.111 (discussing "economic credentialing" whereby hospitals facing competition from specialty providers revoke the admitting privileges of physicians involved with those providers).

bring non-meritorious but costly challenges to their peer reviews. *See id.*, § 11101.

HCQIA provides that "[i]f a professional review action (as defined in section 11151(9) of this title) of a professional review body meets all the standards specified in section 11112(a) of this title," it shall not be liable for damages related to that action. *Id.*, § 11111(a)(1). Thus, the plain language of the Act requires an action to satisfy two tests to obtain immunity from damages: first, it must meet the definition set out in Section 11151(9), and second it must comply with additional standards in Section 11112(a).

The first test, Section 11151(9), defines a "professional review action" as "an action or recommendation of a professional review body which is taken . . . based on the competence or professional conduct of an individual physician." *Id.*, § 11151(9). Section 11151(9) further provides, however, that an action will not be deemed to be based on the competence or professional conduct of a physician – and therefore will not be a "professional review action" – if the action is primarily based on one of five exceptions, including "the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business." *Id.*, § 11151(9)(B).[10] These limits

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[10] The four other exceptions are: "the physician's association, or lack of association, with a professional society or association," "the physician's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis," "a physician's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional," and "any other matter that does not relate to the competence or professional conduct of a physician." 42 U.S.C. §§ 11151(9)(A), (C)-(E). These exceptions were inserted because

(continued....)

on the definition of "professional review action" are explicit and critical.

The second test, Section 11112(a), sets out additional standards necessary for a professional review action to qualify for immunity, including the reviewing body's "reasonable belief that the action was in the furtherance of quality health care." *Id.*, § 11112(a)(1).[11]

Contrary to the plain language of the Act, the Third Circuit effectively held that so long as an action meets the second test, the action or recommendation of a hospital's professional review body will automatically pass the first test and will be deemed a "professional review action" based on a physician's competence or professional conduct. Thus, according to the Third Circuit, "even when the solicitation exception [to the definition of professional review action] is in play, immunity will be judged by applying the objective standard [of the second test] regarding whether the Hospital based its actions upon the reasonable belief that they are in furtherance of quality healthcare." App. at 31-32. The Third Circuit's holding therefore eviscerates Congress's decision to categorically limit the range of actions entitled to immunity, while applying a presumptively reasonable

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"this area presented the greatest potential for abuse of the professional review process for economic or other reasons under the guise of improving the quality of health care." H.R. Rep. No. 99-903, pt. 1, at 6404 (1986).

[11] Section 11112(a) further states that "[a] professional review action shall be presumed to have met the preceding standards necessary for [immunity from damages] unless the presumption is rebutted by a preponderance of the evidence." Accordingly, Section 11112(a) will not even apply unless the act in question has already satisfied the definition of a "professional review action."

standard to a hospital's determination. The result expands the range of physician conduct that can be the basis for adverse action that qualifies for immunity and broader protection for anticompetitive behavior than the law provides.

In addition to defeating the plain language of the Act, this holding confounds the longstanding Supreme Court teaching that exemptions to the antitrust laws are to be construed narrowly. *See Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 126 (1982); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 231 (1979).

By subsuming the categorical exclusion of five specific exceptions in the test for reasonableness, the Third Circuit created a split with the Fifth Circuit, which had previously affirmed the separate application of both tests in their proper order. *See Rogers v. Columbia/HCA*, 971 F. Supp. 229, 234 (W.D.La. 1997) (determining act was a professional review action not fitting any exceptions set out in § 11151(9)(A)-(E) before proceeding to second test of § 11112(a)), *aff'd*, 140 F.3d 1038 (5th Cir. 1998) (mem). As such, the holding is appropriate for certiorari under Supreme Court Rule 10(a).

C. The Evisceration Of The Exceptions From HCQIA Immunity Conflicts With The Policies Underlying HCQIA And The Antitrust Laws.

In the 1970s and early 1980s, following the Supreme Court's decision in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), antitrust law began to be applied actively in the health care field and in the professions. The litigation that followed challenged longstanding practices and premises in the professions and in the health field. The courts and antitrust enforcement agencies regularly confronted claims that restraints were justified because the competition engendered by otherwise professionally-proscribed market conduct would be harmful to patients or consumers – in

effect, that competition itself was unreasonable. Such restraints were often directed at advertising and solicitation activities; discounting; physicians practicing or cooperating with non-physician health care providers who compete with some physicians, such as nurse midwives, podiatrists, or chiropractors; affiliating with health maintenance organizations ("HMOs") or prepaid group health plans; and engaging in the salaried "corporate" practice of medicine. Numerous antitrust cases successfully challenged many of these restraints.[12] As the Supreme Court reemphasized in *National Society of Professional Engineers v. United States*, 435 U.S. 679, 695 (1978), an attempt to justify a restraint under the rule of reason "on the basis of the potential threat that competition poses to the public safety and the ethics of its profession is nothing less than a frontal assault on the basic policy of the Sherman Act."

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[12] *FTC v. Ind. Fed'n of Dentists*, 476 U.S. 447, 463-64 (1986) (rejecting claim that "an unrestrained market in which consumers are given access to the information they believe to be relevant to their choices will lead them to make unwise and even dangerous choices"); *Am. Med. Ass'n v. FTC*, 94 F.T.C. 701, 1037-39 (1979) (striking association's ethics code-based restrictions on advertising, corporate practice of medicine, and affiliation with prepaid group health plans), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd per curiam by an equally divided Court*, 455 U.S. 676 (1982); *In re Mem'l Med. Ctr.*, 110 F.T.C. 541, 546-47 (1988) (consent order prohibiting medical center staff from denying or restricting hospital privileges to nurse midwives without basis); *Wilk v. Am. Med. Ass'n*, 719 F.2d 207, 211, 222-29 (7th Cir. 1983) (reversing jury verdict where jury instructions suggested that defendants' boycott of chiropractors was lawful if boycotting doctors sincerely believed chiropractics to be "dangerous quackery"); *In re State Volunteer Mut. Ins. Co.*, 102 F.T.C. 1232, 1236-37 (1983) (consent order prohibiting insurance company from applying different underwriting criteria to physicians affiliated with nurse midwives).

At the same time, physicians began using the antitrust laws to challenge individual peer review actions to which they objected, even where the action was based solely on their competence or professional conduct, unrelated to their pricing practices or other competitive activities. These cases generally failed – but not without exception. *See, e.g.*, *Patrick v. Burget*, 486 U.S. 94, 105 & n.8 (1988).[13] Congress, therefore, sought to provide qualified immunity to traditional peer review actions directed at a physician's competence or professional conduct, while being careful to exclude from immunity actions that suppress competitive activity by physicians, regardless of the belief of those imposing the discipline that the disciplinary action would further patient welfare and the quality of care provided.

HCQIA reflects careful line-drawing by Congress. Congress sought, on the one hand, to protect *bona fide* peer review focused on the competence or professional conduct of physicians. On the other hand, Congress recognized that restraints on certain types of physician activity were not appropriate for immunity. Among these activities were professional association memberships; fees; advertising and competitive acts intended to solicit or retain business; participation in HMOs or other health plans; and association with non-physician health care practitioners. Congress declined to extend immunity to restraints imposed to prevent a harm emanating from acts of competition themselves. Congress's approach tracks basic principles of antitrust law.

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[13] Bernard D. Reams, Health Care Quality Improvement Act of 1986: A Legislative History of Publ. L. No. 99-660 [hereinafter "HCQIA Hearings"], 101-02 (1990) (testimony of Arthur N. Lerner) (noting reaction to successful cases).

As a result, a "professional review action" can qualify for antitrust damages immunity if it meets specified standards, including fair process and a reasonable belief that the action furthers quality health care. But irrespective of the hospital's belief to the contrary, if the action is based primarily on the enumerated types of competitive acts by physicians, no immunity is provided. Disciplinary actions based on such conduct are fully subject to the antitrust laws. The plaintiff still may not win a suit -- after all, actions not immune under HCQIA are not presumed to violate the antitrust laws. *See* HCQIA Hearings, *supra* note 13, at 6393 ("failure to meet the standards of [the Act] creates no presumption with respect to the liability or lack of liability of a health care entity"). Many hospital peer review decisions, even though not exempt, have no harmful impact on competition or may actually foster it. Rather, where there is no immunity, plaintiffs merely get their day in court.

In holding that these categorical exceptions were subsumed by a reasonableness test focused on furtherance of quality health care, the Third Circuit undermined Congress's approach. Under that court's analysis, a hospital and its medical staff would be immune from antitrust damages for revoking the hospital privileges of a doctor who, for example, discounts his or her fees, joins an HMO, advertises, or collaborates with a nurse midwife, if the hospital reasonably believed that its actions furthered quality health care. This must be wrong. It was not Congress's intent to immunize a hospital that enforced a price-fixing or boycott scheme through peer review if it proffers a reasonable argument that it seeks to further quality health care.

Similarly, the Third Circuit's approach would extend antitrust damages immunity to hospitals that excluded physicians who advertised or otherwise communicated the relative cost, convenience or service advantages of ASC

services to prospective patients, so long as the reasonableness standards were met. Such a result could be devastating for non-hospital affiliated ASCs across the country, since doctors would have to, in effect, re-litigate in each instance whether the competition they sought to foster, and the hospital to restrain, would further quality health care or not. Such restraints do not qualify as professional review actions in the first place, and should enjoy no immunity.

The specific activity by Dr. Gordon that was the primary basis for the Hospital's disciplinary action is a fact issue, and whether that activity fits within any of the enumerated exceptions to the definition of "professional review action" is similarly a fact issue. Those issues are not properly resolved, however, by inquiries into whether the Hospital believed it was furthering quality health care and into the reasonableness of such a belief.

D. Legislative History Supports Application Of The Antitrust Exceptions From HCQIA Immunity.

The legislative history of the Act is compiled in HCQIA Hearings, *supra* note 13. The House's Committee Report on HCQIA confirms that "[t]o qualify for the [immunity] protection, the professional review action must meet the standards specified in section 102(a) [§ 11112(a)] and must be an action as defined in section 301(9) [§ 11151(9)]." *Id.* at 6391 (emphasis added). Other sections of the history concur that the immunity sections of Section 11112(a) were not meant to subsume the exceptions to professional review actions defined in Section 11151(9).[14] The Third Circuit's holding is to the contrary.

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[14] *See, e.g.*, HCQIA Hearings, *supra* note 13, at 47-49 (statement of Henry A. Waxman, Chairman, House Subcommittee on

(continued....)

II. This Court Should Consider Whether A Restraint Imposed On A Potential Or Incipient Competitor Can Be Horizontal In Nature Even If The Competitor Has Not Yet Commenced Operations.

The Third Circuit held that the restrictive "Conditions of Reappointment" that Dr. Gordon entered into with the Hospital on November 14, 1996 in order to be reinstated did not unlawfully restrain trade under the rule of reason. The court applied a "full" rather than a "quick look" rule of reason analysis, categorizing the relationship between Dr. Gordon and the Hospital as a "vertical" relationship between a single hospital and a single physician. In support, the court relied on a conclusion that "Gordon and the Hospital were not competitors in the relevant market in November 199[6][15] when he agreed to the Conditions. His competition in the facility services market did not commence until MCCSC opened more than one year later [in 1998]." App. at 41. In essence, the court found that to the extent proper analysis of an allegedly anticompetitive restraint depends on the existence of a relationship of competition between two

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Health and Environment) ("as *redrafted*, our bill applies *only* to professional review actions based on the competence or conduct of an *individual* physician. We completely *exclude* from the protections of the bill, any disciplinary action based on a doctor's membership or lack of membership in a medical society . . ."); *id.*, at 103, (statement of Arthur N. Lerner) (noting that the exclusions prevent application of immunity); *see also id.*, at 6404 (quoted *supra* at n.10, noting that antitrust exceptions were inserted due to concern for abuse for economic and related reasons).

[15] We note from Dr. Gordon's petition for certiorari that the Third Circuit's opinion makes a typographical error in listing the date of Dr. Gordon's agreement as November 1995 rather than 1996. *See* Pet. for Cert. at 24 n.2.

parties, no competitive relationship will be found when the new entrant has yet to open for business. The court erred and the implications of this error are grave. The court's error is starkly inconsistent with this Court's precedents, with decisions of other circuits, and with accepted antitrust analysis, importantly undermining a significant aspect of antitrust analysis in this field.

Antitrust law recognizes the centrality of new entry and incipient competition to the vitality of the marketplace; this Court's precedents apply the antitrust laws to protect such competition. In *United States v. El Paso Natural Gas Co.*, 376 U.S. 651, 662 (1964), the Court ordered El Paso Natural Gas to divest Pacific Northwest, which it had acquired. The Court found that the acquisition lessened competition even though Pacific Northwest had not yet sold any natural gas in competition with El Paso in the California relevant market. Pacific Northwest had been on the verge of doing so, and had entered into negotiations and a tentative agreement for a supply contract with a prospective customer. *Id.*, at 660-61. In *United States v. Marine Bancorporation*, 418 U.S. 602, 623-25 & n.24 (1974), the Court discussed the El Paso ruling, and, notably, described El Paso as an "actual competition rather than a potential competition case."[16]

In Sherman Act Section 1 cases, courts often apply strict scrutiny to restraints directed at the actions of firms in

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[16] See also *In re Brunswick Corp.*, 94 F.T.C. 11 (F.T.C. 1979) (Pitofsky, C.), *aff'd on other grounds sub nom., Yamaha Motor Co. v. FTC*, 657 F.2d 971, 980-81 (8th Cir. 1981), *cert. denied*, 456 U.S. 915 (1982). The FTC had determined that Brunswick's venture with Yamaha unlawfully lessened "actual competition" in the United States outboard motor market, even though Yamaha had made no sales into the country. The Eighth Circuit held that the joint venture unlawfully lessened "actual potential competition."

potential competition, recognizing that such restraints can be horizontal in character, even though actual competition, in the sense of commercial business operations in the same relevant market, has not yet occurred. For example, in *Palmer v. BRG*, 498 U.S. 46 (1990) (per curiam), defendants argued that vertical analysis was appropriate because they were only potential and not current competitors, and because the challenged dealings between them were vertical. The Eleventh Circuit agreed, but this Court reversed, finding the challenged covenant to be "illegal on its face." *Id.*, at 50.[17] *See also United States v. Reicher*, 983 F.2d 168, 170 (10th Cir. 1992) (applying horizontal *per se* standard although one of the two competitors did not have the capacity to perform the contract); *United States v. MMR Corp.*, 907 F.2d 489, 498 (5th Cir. 1990) (affirming decision that company lacking capacity to enter the market was a competitor, because it "was a competitive threat"); *Engine Specialties, Inc. v. Bombardier Ltd.*, 605 F.2d 1, 11 (1st Cir. 1979) (holding that a contract not to compete between a manufacturer and potentially competing distributor was *per se* illegal).

The Third Circuit's notion that two facilities are not competitors for purposes of antitrust analysis until the second facility opens its doors is peculiar and contrary to past decisions and common sense. The antitrust laws must protect doctors desiring to affiliate with ASCs against a dominant hospital's anticompetitive acts as soon, for example, as the physician's definite steps toward opening or providing services through an ASC makes him or her a potential or incipient competitor. As the Court explained in

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[17] *See also Palmer v. BRG*, 874 F.2d 1417, 1432-33 (11th Cir. 1989) (Clark J., dissenting) ("It is firmly established that entities in a seemingly vertical relationship may be capable of horizontal restraints if they are actual or potential competitors.").

El Paso, a firm's competitive significance in a market "is determined by the nature or extent of that market and by the nearness of the absorbed company to it, that company's eagerness to enter that market, its resourcefulness, and so on." 376 U.S. at 660. Under this analysis, "Pacific Northwest's position as a competitive factor in California was not disproved by the fact that it had never sold gas there." *Id.* By any measure, Dr. Gordon was a competitor of the Hospital when the challenged restraints occurred.

Opening an ASC can be an arduous process. The CON procedure in some states, such as Pennsylvania's during the time in question, was highly regulated, costly, and time-consuming. Hospitals often hold the key for ASC entry, as the federal government and many state regulatory agencies require physicians who seek to open or work at an ASC to have privileges at a hospital. In this way, ASCs are particularly vulnerable when they are still nascent, and the doctors who support them are then most in need of antitrust protection. A finding that antitrust protections for ASCs and doctors who work with them do not fully ripen until their doors are actually open for business poses severe risks for ASCs, for competition, and for consumers.

Appropriate antitrust analysis of hospital-physician interactions can be complicated. Questions regarding applicability of the *per se* rule and of "quick look," "sliding scale" or full-blown rule of reason standards can arise. The answer to these questions may depend on a variety of factors, and the mere fact that parties are in some regards competitors does not condemn any and all agreements between them necessarily to *per se* or "quick look" treatment. It is equally evident, though, that to the extent an agreement's horizontal character makes a difference in antitrust analysis, it is wholly unsound to decide that question by application of an all-or-none "are they

competitors" test that turns on whether the target of the restraint has yet opened his or her doors.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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IN THE

Supreme Court of the United States

ALAN D. GORDON, M.D.; ALAN D. GORDON, M.D., P.C., a Corporation; MIFFLIN COUNTY COMMUNITY SURGICAL CENTER, INC., a Corporation,

Petitioners,

v.

LEWISTOWN HOSPITAL,

Respondent.

ON A PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

MOTION TO FILE BRIEF AMICI CURIAE AND BRIEF OF AMERICAN OSTEOPATHIC ASSOCIATION AND PENNSYLVANIA OSTEOPATHIC MEDICAL ASSOCIATION IN SUPPORT OF PETITIONERS

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MOTION FOR LEAVE TO FILE AMICI CURIAE BRIEF OF THE AMERICAN OSTEOPATHIC ASSOCIATION AND PENNSYLVANIA OSTEOPATHIC MEDICAL ASSOCIATION

The American Osteopathic Association ("AOA") and Pennsylvania Osteopathic Medical Association ("POMA") (collectively the "*Amici*") respectfully move this Court, pursuant to Rule 37.2(b), for leave to file a brief as *Amici Curiae* in support of the petition for a writ of certiorari to the United States Court of Appeals for the Third Circuit. Petitioners have consented to the filing of this brief, but respondent has declined to consent, thereby necessitating this motion. A copy of the proposed *amici curiae* brief is attached.

As more fully explained at pages 1-2 of the attached brief, under "Interest of *Amici Curiae*," the AOA was founded in 1897 and is the national association that serves more than 56,000 osteopathic physicians practicing in the United States. The POMA was founded in 1903 and is the state association for osteopathic physicians who practice in Pennsylvania. Osteopathic physicians have historically been subjected to discrimination in the medical community, particularly in the area of credentialing and privileging at hospitals.

Amici seek leave to file this brief on the narrow question of the statutory construction of immunity under the Health Care Quality Improvement Act ("HCQIA"). In passing the HCQIA, Congress sought to promote and protect peer review of Medical professionals. At the same time, Congress also sought to prevent the peer review process from being abused by creating exceptions to the otherwise blanket immunity hospitals could enjoy under the HCQIA. The Third Circuit's decision threatens to eliminate these protections.

The *Amici* are uniquely positioned to address the HCQIA statutory construction question presented from the perspective of the minority physician population, a population that the exceptions to immunity under the HCQIA were originally enacted to protect. The *Amici* believe they can assist the Court by demonstrating how the Third Circuit's ruling reads the exception Congress enacted to protect them, and others similarly situated, out of the statute; and how its approach shifts the burden of proof in establishing HCQIA immunity from the movant, to the victim of an improper peer review, of the type *Amici's* members may face.

For these reasons and those set out in the accompanying brief, AOA and POMA hereby move the Court to allow them to appear as *Amici Curiae*, and to submit their brief urging the Court to grant the Petition and reverse the decision of the Court of Appeals for the Third Circuit.

Respectfully submitted this 13th day of March, 2006.

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INTEREST OF *AMICI CURIAE* [1]

The American Osteopathic Association ("AOA") is the national association for osteopathic medicine. The AOA serves as the professional association for more than 56,000 osteopathic physicians ("Doctors of Osteopathic Medicine or "DOs") practicing in the United States. The AOA is also recognized by the United States Department of Education as the accrediting agency for osteopathic medical schools and also accredits osteopathic graduate medical educational programs (i.e., internships, residencies and fellowships) and continuing medical education programs throughout the United States. The Pennsylvania Osteopathic Medical Association ("POMA") is the state association for the approximately 6,000 osteopathic physicians who practice in Pennsylvania. POMA has the largest number of osteopathic physicians of any state and Pennsylvania. There are two osteopathic medical schools in Pennsylvania.

Osteopathic physicians (Doctors of Osteopathy or DOs) are eligible to be licensed for the full scope of medical and surgical practice in every state in the United States, but osteopathic physicians remain a minority of the physician work force, accounting for roughly 8% of that work force. Historically, DOs have been subject to discrimination in the medical community, particularly where economic forces bring DOs into competition for patients. The discrimination has been most prevalent in the area of credentialing and privileging at hospitals. E.g., *Weiss v. York Hospital*, 745 F.2d 786 (3d Cir. 1984); *Welchin v. Tenet Healthcare Corp.*, 366 F. Supp. 2d 338 (D.S.C. 2005); *Fritz v. Huntington Hospital*, 39 N.Y.2d 339 (N.Y. 1976); *Greisman v. Newcomb Hospital*, 40 N.J. 389 (N.J. 1965). While ethical principles indicate that hospital medical staff privileges should not be based on "personal friendships, antagonisms, jurisdictional disputes,

1. Counsel for a party did not author this brief in whole or in part. No person or entity, other than the *Amici Curiae*, has made a monetary contribution for the preparation and submission of this brief.

or fear of competition" (AMA Code of Medical Ethics, Section 4.07 (2004)), credentialing, privileging and peer review decisions can, and do, turn on issues of competition disguised as quality of care issue.

Because it is essential for osteopathic physicians to be able to admit their patients into hospitals and for osteopathic specialty physicians to have access to hospital facilities, osteopathic physicians must be able to secure relief in the event that peer review processes are abused for economic advantage of competing physicians. Until the Third Circuit's decision below, the exceptions from immunity Congress provided under the Health Care Quality Improvement Act ("HCQIA") afforded that protection and permitted health care providers in the minority (such as osteopathic physicians and podiatrists), to sue for, *inter alia*, antitrust violations, for actions primarily based on the physician's association with a particular class of health care professional. The Court should grant certiorari, reverse the decision below, and confirm that a "reasonable belief" that an anti-competitive action was taken in the interest of patient care does not void the plain statutory exceptions Congress provided.

SUMMARY OF ARGUMENT

The AOA and POMA petition in support of certiorari here on the narrow issue of whether a "reasonable belief in furtherance of quality health care" should be allowed to override the enumerated exceptions to HCQIA-conferred immunity, and whether the burden of establishing such an immunity falls on a plaintiff. The AOA and POMA respectfully submit that the reasonable belief should not override the law and the burden to establish immunity should remain with a defendant. Certiorari should be granted to confirm this precisely so that health care entities, such as hospitals, do not use the Third Circuit decision below to attempt to shield anti-competitive actions from liability by placing the decisions in the guise of a "reasonable belief."

The stakes are high here not only for physicians who may be viewed as competitors by hospitals, but also for health care providers in the minority such as osteopathic physicians. Hospitals could, for example, based on the Third Circuit decision, take action against osteopathic physicians and order other physicians or hospital employees not to refer to osteopathic physicians or associate with them because of a purported "concern for patient health and welfare." Under the Third Circuit's ruling, such blatantly anti-competitive behavior would be immune so long as the hospital based its actions upon the "reasonable belief" that they were acting in furtherance of the quality of health care. (Petitioner's Appendix 31-32). This interpretation strips the law of any practical effect and reads the exceptions out of the law. This dangerous precedent eviscerates Congressional intent and puts health care practitioners and health care itself at risk. Under Supreme Court Rule 10(c) "it is an important question of Federal law that has not been, but should be, settled by this Court."[2]

The Third Circuit's decision also contradicts other Circuit decisions and established Supreme Court precedent that placed the burden of establishing an affirmative defense, such as immunity, rests on the defendant. Again, the decision contradicts the plain language of the statute that creates a presumption that the health care entity had a reasonable belief it was acting in furtherance of quality health care only if its actions first qualify as a "professional review action." The

2. Respondent may suggest there is no circuit split on this issue and, therefore, certiorari should not be granted. *Amici* respectfully submits there is no split because the decision on this issue directly contravenes the plain language of the statute. Waiting for "percolation" will only allow the precedent to create more harm and is not a reason to permit it to stand. The decision does contradict established Supreme Court law on statutory construction and other Circuit decisions on where the burden of proving immunity lies.

statute establishes no presumption that any act is a professional review action or that it is a plaintiff's burden to show it is not. Certiorari should be granted.

I. CERTIORARI SHOULD BE GRANTED BECAUSE THE RULING BELOW READS THE EXCEPTIONS TO IMMUNITY OUT OF THE STATUTE.

A. A Statute Is Read to Give Effect to All Its Parts.

The Health Care Quality Improvement Act ("HCQIA") is a statute that grants health care delivery organizations immunity from money damage suits based on defined peer review activities. When Congress enacted the HCQIA, however, it recognized that hospitals and other health care organizations had a long history of abusing the credentialing and peer review processes for anticompetitive and exclusionary purposes, including the exclusion of physicians in a particular class of health care professionals such as DOs. *See, e.g., Weiss v. York Hospital*, 745 F.2d 786 (3d Cir. 1984). As a result, the HCQIA contains a series of exceptions that deny immunity to a health care entity when a disciplinary action is primarily based on a physician's association with a class of professional (like DOs) or a physician's competitive conduct such as advertising or patient solicitation, both of which have been traditionally attacked as "unprofessional" by interested parties in the hardscrabble world of healthcare delivery. The decision below, if allowed to stand, makes those statutory exceptions created by Congress a dead letter.

The relevant portions of the HCQIA at issue here are plain on their face. Hospital disciplinary actions that amount to a "professional review action" are entitled to immunity if the professional review action was taken in furtherance of quality health care and meets other due process requirements. The HCQIA, at 42 U.S.C. § 11151(9), defines a "professional review action" as:

> (9) [A]n action or recommendation of a professional review body which is taken or made

> in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may effect) adversely the clinical privileges . . . of the physician . . .

The definition of a "professional review action," however, then goes on to exclude or "carve out" certain actions from the scope of a "professional review action":

> [A]n action is not considered to be based on the competence or professional conduct of a physician [and thus is not a professional review action] if the action is primarily based on (A) [text omitted here]
>
> (B) the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business . . .
>
> (C) [text omitted here]
>
> (D) a physician's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional, or . . .
>
> (E) [text omitted here]

42 U.S.C. § 11151(9).

As the language above plainly reveals, Paragraphs 9(D) and 9(B) deny a hospital immunity when it decides to discipline a physician primarily for competitive conduct or for associating with or delegating authority to osteopathic physicians and other classes of practitioners. In those circumstances, the action is not considered a "professional review action" under the statute and, consequently, its